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13 MAY 2025

MEMORANDUM FOR: ALL DEFENSE HEALTH AGENCY (DHA)
MILITARY MEDICAL TREATMENT FACILITIES

SUBJECT: Guidance for Military Medical Treatment Facilities and Force Health Protection Staff in Response to Measles

This memorandum provides information and guidance to military health staff in response to the ongoing outbreaks of measles in the United States. Measles is a highly contagious infectious disease which can result in severe illness. It is imperative we protect the force from this disease to maintain warfighter readiness and mission effectiveness.

On 7 March 2025, the CDC issued a Health Alert Network (HAN) Health Advisory to clinicians and laboratories due to an outbreak of measles centered in Texas and New Mexico. Between January 1 and May 8, 2025, the Centers for Disease Control and Prevention (CDC) has been notified of 1,001 confirmed U.S. cases of measles in 31 jurisdictions and 14 outbreaks (defined as three or more cases), with the largest outbreak in Texas and New Mexico accounting for more than 90% of cases. Most of these cases were among children and adolescents who had not received a measles vaccine or whose vaccination history was unknown. (https://www.cdc.gov/measles/data-research/)

Leaders will ensure widest distribution of this memorandum to our healthcare facilities. This guidance is being shared with the military departments and combatant commands (CCMDs) for information and promulgation to their Public Health Emergency Officers (PHEOs) and force health protection staff. Close coordination with PHEOs, CCMD staff, and local public health jurisdictions is essential to an effective response.

The point of contact for this memorandum is Dr. Eric Deussing, DHA PHEO. Please direct all inquiries to the DHA Public Health Operations Box at: dha.ncr.pub- health.mbx.operation@health.mil. Locate this memo along with updates on the Medical Affairs homepage at: https://militaryhealth.sharepoint-mil.us/sites/DADMA.

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Attachment:
Guidance for MTFs and Force Health Protection staff in Response to Measles

Defense Health Agency (DHA)

Guidance for Military Medical Treatment Facility and Force Health Protection Staff in Response to Measles

Date: 01 MAY 2025

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Vaccination

Vaccination is the best way to prevent measles infection. Two doses of the Measles, Mumps, and Rubella (MMR) vaccine result in 97% protection from measles infection. In areas with ongoing measles outbreaks, follow state and local guidance. As of this writing, outbreak-based vaccine recommendations have been issued by Texas (https://www.dshs.texas.gov/news-alerts/measles-outbreak-case-definition) and Kansas (https://www.kdhe.ks.gov/civicalerts.aspx?AID=1493).

Standard Childhood Vaccination Recommendations

- Receive first dose of MMR vaccine at 12-15 months of age.
- Receive second dose at 4-6 years of age, before school entry.

Outbreak-Based Recommendations

- Infants 6-11 months of age:
  - Receive an early dose of MMR vaccine.
  - Follow Advisory Committee on Immunization Practices (ACIP) recommended schedule and receive routine pediatric MMR series - 2-dose series with 2nd dose at 12-15 months (at least 28 days after early "6-11 months" dose) and final (3rd) dose at 4-6 years.

- Children >12 months of age:
  - If not yet vaccinated, receive one dose immediately and with 2nd dose at least 28 days later.
  - If child has one prior dose, receive early 2nd dose of MMR vaccine separated by at least 28 days.

- Teenagers and adults previously vaccinated with one dose of MMR vaccine should receive 2nd dose of MMR vaccine at least 28 days after their first dose.

- Individuals with no evidence of immunity should receive one dose of MMR vaccine immediately and follow 2nd dose at least 28 days later.

- Post-exposure prophylaxis (PEP) – Provide appropriate measles PEP to close contacts without evidence of immunity, as soon as possible after exposure, either with MMR vaccine (within 72 hours) or immunoglobulin (within 6 days). The choice of PEP is based on elapsed time from exposure or medical contraindications to vaccination. Follow CDC guidance at: https://www.cdc.gov/measles/hcp/vaccine-considerations/index.html for PEP considerations.

International Travel

- Ensure all U.S. residents older than age 6 months without evidence of immunity who are traveling internationally receive MMR vaccine prior to departure.

- Infants 6-11 months of age:
  - Receive an early dose of MMR vaccine before departure.
  - Infants who receive a dose of MMR vaccine before 1st birthday should receive 2 more doses of MMR vaccine; 2nd dose administered when child is 12-15 months of age and 3rd dose at least 28 days later (generally at age 4-6 years of age but can be administered sooner if indicated).

- Children 12 months of age or older should receive two doses of MMR vaccine, separated by at least 28 days.

- Teenagers and adults without evidence of measles immunity should receive two doses of MMR vaccine separated by at least 28 days.

Healthcare Worker

- Healthcare personnel without presumptive evidence of immunity should be offered 2 doses of MMR vaccine, separated by at least 28 days.

- Although birth before 1957 is considered acceptable evidence of immunity in routine circumstances, healthcare facilities should consider vaccinating healthcare personnel born before 1957 who lack laboratory evidence of immunity or laboratory confirmation of disease.

Clinical Presentation[1]

Measles is characterized by a prodrome of fever (up to 105 °F), malaise, cough, coryza (acute inflammation of mucous membrane inside the nose), and conjunctivitis, a pathognomonic exanthem (Koplik spots), followed by a maculopapular rash. The rash usually appears about 14 days after a person is exposed. The rash spreads from the head to the trunk to the lower extremities. Immunocompromised patients may not develop the rash.

Consider measles in patients presenting with febrile rash illness and clinically compatible measles symptoms, especially if the person recently traveled internationally, or domestically to a region with a known measles outbreak, or has other known or suspected exposure to measles.

See the Centers for Disease Control and Prevention (CDC) Clinical Overview of Measles (https://www.cdc.gov/measles/hcp/clinical-overview/index.html) for more information.

[1] See Armed Forces Reportable Medical Events Guidelines and Case Definitions (https://www.health.mil/Reference-Center/Publications/2022/11/01/Armed-Forces-Reportable-Medical-Events%20Guidelines)

Laboratory Analysis

To ensure accurate and timely measles testing, all Military medical treatment facilities (MTFs) are required to coordinate with their state public health laboratories *before* collecting specimens from suspected cases. This coordination will establish adherence to state-specific guidelines and requirements. Please confirm all public health testing prerequisites are met and that all requested investigation information accompanies sample submissions. Samples must be handled and transported in accordance with the guidelines provided by the respective state health department. State public health labs will then be advised to support genotyping, depending upon the respective testing algorithm, to have the sample submitted to the CDC.

If commercial laboratories (e.g., LabCorp) are used for testing, personnel at the medical treatment facility (MTF) should obtain two samples, one for testing at a public health lab and the second for testing at non-governmental laboratories. MTFs within the state of Texas should already have submission specimen forms and submission IDs. As such, those MTFs should notify the Texas Department of State Health Services to submit specimens for genetic sequencing.

Test ordering can be either named Measles or Rubeola. Please contact your MTF laboratory for proper ordering nomenclature. Obtain both a serum sample and a throat swab (or nasopharyngeal swab) from patients suspected to have measles. Collecting both respiratory and serum samples can increase the likelihood of detecting measles virus. The throat or nasopharyngeal swab will be used for Measles Real Time Polymerase Chain Reaction test, and the serum will be used for Measles IgM and/or IgG serology test(s). The MTF laboratory should contact the reference lab for the required specimen storage and shipping temperatures. MTFs will be responsible for payment of testing performed at the reference laboratory (i.e. State Public Health Lab or commercial lab).

For questions on diagnostic testing, contact your local Chief of Pathology/Laboratory Manager or the Center for Laboratory Medicine Services (CLMS) at dha.ncr.clinic-support.mbx.clms@health.mil.

Measles Reporting

Any probable or confirmed cases of measles should be reported using the Disease Reporting System internet (DRSi), as outlined by the 2022 Armed Forces Reportable Medical Events Guidelines and Case Definitions. A copy of the case definition has been included in the attachment. Measles has been designated as an urgently reportable event, which requires immediate reporting within DRSi. Report any potential case of measles immediately within 12 hours of identification to DRSi regardless of laboratory results. All domestic measles cases must also be reported to the local civilian public health department according to cognizant state health regulations.

The DRSi can be accessed at https://drsi.health.mil/DRSi. For assistance with DRSi, please contact the DRSi help desk at dha.apg.pub-health-a.mbx.disease-epidemiologyprogram13@health.mil or 410-417-2337.

To report probable cases of measles:

- Probable cases of measles are unverified cases that do not presently meet the "Confirmed" case definitions per the 2022 Armed Forces Reportable Medical Events Guidelines and Case Definitions, though may be verified later. These are likely to be instances of illness with clinical consistency to measles.
- ***Probable cases should be entered into DRSi as soon as there is suspicion of measles and/or testing for measles is initiated.***
- Probable cases are required to be reported through DRSi, utilizing the "Preliminary" case status and "Probable" case classification.
- As soon as any applicable laboratory tests result are certified and released, the case in DRSi should be updated to the appropriate case classification as outlined in the measles case definition in the attachment.
- Please note - there is no "Suspect" case classification for measles. Please report only using the "Probable" or "Confirmed" case classifications.

To report confirmed cases of measles:

- Confirmed cases of measles should be reported through DRSi using the "Final" case status if all information is available, or "Preliminary" if information is pending.
- The case classification should be set to "Confirmed" if the case has positive laboratory results that meet the case definition requirements as outlined in the case definition, or an epidemiologically linked case that meets the clinical description as outlined.
- Confirmed cases of measles must be entered into DRSi as soon as possible, with the case status updated to "Final" once all information has been entered.

To update cases reported in DRSi:

- For any preliminary cases of measles reported in DRSi that return with negative test results, please change the case classification to "Not a Case" and the case status to "Final."

Case Investigation and Contact Tracing

To assist in case contact investigation, utilize the Communicable Disease Toolkit at the following link: https://ph.health.mil/topics/healthsurv/de/Pages/cdt.aspx

A thorough patient and provider interview is essential in determining clinical compatibility and the source of infection. The interview should answer the following:

- Symptoms, including timing of prodromal symptoms: cough, coryza, conjunctivitis, and fever (max temperature)
- Date of symptom onset
- Date of rash onset
- Description of rash: how does it look, where did it start, how did it progress,

- How long did the rash last?
- Vaccination status and dates

In addition to clinical symptoms, a detailed patient history should be obtained for the 21 days preceding rash onset. This may help to identify the source of exposure. Examples include but are not limited to:

- Travel in and out of county/state/country
- Sick contacts or contact with known cases
- Contact with recent travelers
- Events or gatherings attended (concerts, conferences, festivals, resorts, theme parks, casinos, other tourist destinations, etc.)

Contact Investigation

MTF staff should coordinate with local public health authorities on contact tracing for all suspected and confirmed measles cases to ensure a unified approach.

A close contact is anyone with potential direct exposure to an infectious person or those with anything but brief exposure to shared airspace within 2 hours of the infectious person's presence. Collecting a detailed history for the person's infectious period (4 days prior to rash onset through 4 days after rash onset) is crucial to identify close contacts and settings where exposure may have occurred. Be sure to ask about any places the case may have visited during this timeframe. Examples include but are not limited to:

- Medical facilities: pharmacies, urgent care, hospitals, doctor offices (including waiting rooms)
- Childcare facilities
- Schools or college campuses
- Restaurants
- Grocery stores
- Gyms
- Events or gatherings
- Lodging (e.g., hotels, resorts)
- Religious Gatherings (e.g., Church, Temple, Mosque)
- Public transportation (e.g., buses, taxis, trains, airplanes)

Evaluation of Immunity

Close contacts should first be evaluated for their immunity to measles.

Presumptive Evidence of Immunity for Healthcare Workers

- Documentation of 2 Measles, Mumps, and Rubella (MMR) vaccines
- Documented positive Rubeola Immunoglobulin G (IgG)

- Healthcare workers confirmed to have evidence of immunity may continue working with no restrictions. Those without presumptive evidence of immunity must be furloughed from day 5 through 21 after exposure (day 28 if immunoglobulin (IG) administered) regardless of PEP administration.

Presumptive Evidence of Immunity for Non-Healthcare Workers

- Documentation of 2 MMR vaccines
- Documented positive Rubeola IgG
- Born before 1957

Contact Monitoring

Close contacts without evidence of immunity and not receiving an MMR vaccine within 72 hours of their initial exposure should receive daily symptom monitoring by public health staff and comply with quarantine guidance for 21 days following their last exposure. If the contact receives IG, they should be monitored for 28 days following their last exposure.

Contacts with evidence of immunity or receiving the MMR vaccine within 72 hours of their initial exposure should be educated on signs and symptoms of measles and instructed to isolate and notify the Installation Public Health Department should any symptoms develop.

Clinical Management[2]

There is no specific antiviral therapy for measles. Medical care is supportive and to help relieve symptoms and address complications such as bacterial infections.

Vitamin A

According to the CDC, under the supervision of a healthcare provider, vitamin A may be administered to infants and children in the United States with measles as part of supportive management. There is no indication for using Vitamin A to care for an adult measles patient. See: https://www.cdc.gov/measles/hcp/clinical-overview/ for up-to-date guidance on Vitamin A administration.

Pharmacy can support clinical management of measles through administration of Aquasol 50,000 IU/ML Vitamin A IM injection, to be administered immediately on diagnosis and repeated the next day for a total of 2 doses under physician supervision to prevent hypervitaminosis A. Pharmacy can also dispense Vitamin A 10,000 IU gel capsules (for children old enough to swallow capsules) with a physician's prescription for the recommended age-specific daily doses of Vitamin A in the medical supportive treatment of measles.

Infection Prevention

[2] See CDC: https://www.cdc.gov/measles/hcp/clinical-overview/

Measles is one of the most contagious of all infectious diseases. Up to 9 out of 10 susceptible people with close contact to a measles patient will develop measles.

The virus is transmitted by:

- Direct contact with infectious droplets
- Airborne spread when an infected person breathes, coughs, or sneezes

Measles virus can remain infectious in the air for up to 2 hours after an infected person leaves an area.

Measles cases should be isolated at home away from non-household and unimmunized people during their infectious period, from 4 days before rash onset through 4 days after rash onset. Unimmunized infants in the home are particularly at risk and should be prioritized for PEP.

Details for medical facility control measures can be found here: CDC Interim Measles Infection Control Guidelines.

Public Communications

If there is a possible or confirmed case of measles, ensure subject matter experts, MTF, and installation personnel are informed of current facts and key messaging. Also, the MTF should make sure their messages are aligned with messaging from state and local public health departments, Defense Health Networks, and nearby MTFs dealing with measles cases (possible or confirmed).

For sample key messages, resources, and social media graphics, see the Defense Health Agency measles communication toolkit at: https://militaryhealth.sharepoint-mil.us/sites/DHAComms/SitePages/Measles%20Awareness%20Toolkit.aspx?csf=1&web=1&e=2R1nd2

Attachment: Armed Forces Reportable Medical Events Measles Page[3]

Measles (measles virus)

COMMON NAME: Rubeola

Background

Causative Agent	measles virus
Travel Risks	Present worldwide
Clinical Description	In the absence of a more likely diagnosis, an acute illness characterized by **ALL** of the following: • Generalized, maculopapular rash lasting ≥ 3 days and • Temperature ≥ 101°F or 38.3°C and • Cough or coryza (inflammation of nasal mucous membranes) or conjunctivitis (inflammation of the eye)

Case Classification

Probable:
In the absence of a more likely diagnosis, a case that meets the clinical description as described above where lab results are not available and there is no epidemiologic link to a laboratory-confirmed case

Confirmed:
Any acute febrile rash illness with any of the following:

- Measles virus identified by culture* from any clinical specimen or
- Measles virus nucleic acid* (RNA) detected (example: PCR, sequencing, NAAT) from any clinical specimen or
- Seroconversion from a negative measles IgG followed by a positive measles IgG* in a convalescent sera or
- Significant rise of measles IgG titer between 2 serum samples* or
- Measles positive IgM antibody*[+] from serum or
- Epidemiologically linked to a laboratory-confirmed case

Critical Reporting Elements

Document relevant travel and deployment history occurring within the incubation period.
Note the patient's measles immunization history.

Comments

*Not explained by Measles, Mumps, and Rubella (MMR) vaccination during the previous 6-45 days.
[+]Not otherwise ruled out by other confirmatory testing or more specific measles testing in a public health laboratory.

[3]See Armed Forces Reportable Medical Events Guidelines and Case Definitions (https://www.health.mil/Reference-Center/Publications/2022/11/01/Armed-Forces-Reportable-Medical-Events%20Guidelines)